

Visiting Medical Student Required Immunizations, Titers and Tuberculosis Screening

Brown University requires all visiting medical students to provide written documentation of the following on the Visiting Medical Student Immunization, Titers & Tuberculosis Screening Record:

Hepatitis B

A record of Hepatitis B vaccine, three doses. If series complete, a quantitative Hepatitis B Surface Antibody titer must be done with a copy of the lab report attached.

- Influenza
 A record of Influenza vaccine, received after July 1, 2019.
- □ Measles, Mumps and Rubella

A record of two MMR vaccines **and** positive serological tests for immunity to Measles, Mumps and Rubella. History of disease is not acceptable. A copy of the lab reports must be attached.

Meningococcal

A record of Meningococcal vaccine if under 22 years old. If first dose was given before the age of 16 years, a booster dose must be recorded.

□ Tetanus/Diphtheria/Pertussis

One dose of adult Tdap (Tetanus/Diphtheria/Pertussis). If last Tdap dose is more than 10 years old, then a Tetanus Diptheria booster is also required.

Varicella

Positive serological test for immunity to Varicella (chickenpox) only if a history of chickenpox disease. History of disease alone is not acceptable. A copy of the lab report must be attached **OR** a record of Varicella vaccine, two doses, at least one month apart.

□ Tuberculosis Screening

A record of TWO tuberculosis skin tests (PPD), 1-3 weeks apart **OR** one Quantiferon/TB Spot blood test, done **within 6 months** of arrival at Brown. If there is a positive result to either test, documentation of a negative chest x-ray **and** prophylaxis therapy must be attached.

PLEASE NOTE: ANY DEVIATION FROM FULFILLING ALL OF THE ABOVE HEALTH REQUIREMENTS WILL CAUSE YOUR APPLICATION PACKAGE TO BE RETURNED TO YOU AND DELAY PROCESSING



Visiting Medical Student Immunization, Titers & Tuberculosis Screening Record

lame Last	Fi	rst	Middle	Date of Birth	mm	dd yy	
ddrace							
ddress Street	C	ty	State	Zip Code	Co	ountry	
EQUIRED IMMUNIZATIONS		cy	State	Zip couc		REQUIRED TITERS	
Hepatitis B 3 doses and a quantitative titer required	Date of Dose #1:	Date of I	Dose # 2:	Date of Dose #3:		□ pos □ neg – attached report require Date:	
Influenza	Date:					Dale:	
Received after July 1, 2019	Dale.						
MMR (Measles, Mumps,	Date of Dose #1:	Date of [Dose #2:				
Rubella) 2 doses and titers required or individual vaccines and titers as listed below	Given at 12 months after birth or later		least 1 month				
Measles (Rubeola)	Date of Dose #1: Given at 12 months afte birth or later		Dose #2: least 1 month first dose			pos neg - attached report require Date:	
Mumps	Date of Dose #1: Given at 12 months afte birth or later	Date of I Given at				pos neg - attached report require Date:	
Rubella (German Measles)	Date of Dose #1: Given at 12 months afte birth or later		Dose #2: least 1 month first dose			pos neg - attached report require Date:	
Meningococcal Vaccine Required if under 22 years old	 Menactra Menomune Menveo Other: 	Date of I	Dose #1	Date of Booster Dose: Required if dose 1 was given before 16 years old			
Tdap (Tetanus-Diphtheria- Pertussis)	Date of Tdap Dose:		> 10 years, then Diptheria (Td)	Date of Td dose:			
Varicella (Chicken Pox) 2 doses required or positive titer	Date of Dose # 1:	Date of I	Dose # 2:	2 doses of vaccine or titer required		pos neg - attached report require Date:	
EQUIRED TUBERCULOSIS SCRI	EENING:						
PPD Two skin tests 1-3 weeks apart, wit months of arrival at Brown			Date of Read		Result in		
0.0	Date of Test #2:		Date of Read	#2: Result in		i mm:	
OR IGRA	Date of Test:		Results:	Attach a		ony of lab roport	
Quantiferon Gold or TB Spot	Gold or TB Spot		PositiveNegativeIndeterminate		Attach copy of lab report (required)		
Chest X-ray (Required if PPD or Id test is positive. Must be within 6 mo of arrival at Brown)	onths	Date:		Results: Normal Abnormal		Attach copy of chest x-ray (required)	
Positive Tuberculosis Test Treatment	Type of Treatmen	Type of Treatment:		Date Treatment Started:		Date Treatment Completed:	

Signature of Physician/Medical Provider: _____

Date:

Physician/Medical Provider Name: (Please Print) /Clinic Stamp_____

Address

Phone number: _____ Fax Number: _____